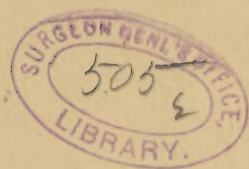


WERDER (X.O.)

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partial suprapubic Hysterec-
tomy for ————



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PREGNANCY FOLLOWING A PARTIAL SUPRA-
PUBIC HYSTERECTOMY, COMPLICATED
BY HEMORRHAGE THROUGH THE
ABDOMINAL CICATRIX.

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THE case which I am about to describe is so interesting and, I believe, unique in many of its features that I choose this opportunity to put it on record.

Mrs. Mary L., twenty-nine years old, married since August, 1890, but sterile, consulted me for the first time in June, 1891. She had been in good health until about five or six months ago, when she noticed a slight enlargement of her abdomen, accompanied by discomfort and, at times, pains in her pelvis. The swelling of her abdomen gradually increased until at the time she first saw me it had attained the size of a five or six months' pregnancy; with the enlargement of her abdomen the discomfort in the pelvis increased. The pains "at the bottom of the bowels" became very severe and were of a bearing-down character. Locomotion was very much interfered with and she was frequently unable to lie down a night. Her digestion became deranged and her health began to fail. While she possessed a fair amount of adipose, she was pale and anemic and the least exertion fatigued her. Her menses, which for years had been somewhat painful, were now accompanied by considerable suffering, though the flow was scanty, lasting only three days. An examination showed a firm, hard, and roundish tumor, occupying the centre of the abdomen and extending from the symphysis pubis to the umbilicus and attached to the posterior surface of the fundus uteri. Tonic treatment continued for three months produced a marked improvement of her general health, but had no effect on the local condition in the pelvis. She was

advised to go to Mercy Hospital, where for two months electricity was applied according to Apostoli's method, a total of fifteen applications in all, varying from 100 to 150 milliamperes. This treatment neither affected the size of the tumor nor did it produce the slightest symptomatic improvement, so that the patient clamored for operation, which was performed December 3, 1891.

The tumor was a fibromyoma attached by a very broad and thick pedicle to the posterior and right surface of the fundus uteri. The base of the tumor was encircled by the elastic ligature closely hugging the uterus, and as subsequent events proved, including a small portion of the uterus itself. The tumor was transfixed with pedicle needles immediately above the elastic ligature and cut off above this point. The uterine cavity had not been opened. The pedicle was fixed in the lower angle of the wound in the usual way. The tumor weighed twelve pounds. Convalescence was uninterrupted. Ligature and pedicle came away on the twentieth day. Patient left the hospital January 17, 1892, about six weeks after the operation, with a small fistulous opening at the bottom of the abdominal wound. Her menstrual period returned February 19, about a month after leaving the hospital, and at this time she noticed a slight bloody discharge from this sinus.

In March her catamenia did not appear at the expected time, and soon afterward other symptoms of pregnancy developed. About this time I found the cervix high up in the pelvis, uterus firmly attached to the abdominal wall, soft, elastic, and enlarged. The fistula in the lower angle of the wound was still open—just about large enough to introduce a sound. A subsequent examination (about a month later) confirmed the diagnosis of pregnancy. She was then having some pain in the pelvis, about the uterine attachment to the abdominal walls. With the exception of this pain, or rather discomfort, her pregnancy progressed very favorably thus far. At the beginning of the fourth month a gradual rotation of the uterus began at its point of fixation to the abdominal wall, *i.e.*, the uterine tumor no longer occupied the middle of the abdomen, but began to crowd more to the left of the median line. During her whole pregnancy, the left side of abdomen was the principal seat of the pregnant uterus, it scarcely reaching beyond the median line toward the right side.

At the end of the fourth month there was a copious hemorrhage

from the fistulous opening at the lower angle of the abdominal cicatrix, which by this time had become enlarged from the internal pressure to the size of a half-dollar, the amount of blood lost being at least a pint, according to the estimate of the patient. About three weeks later there was another hemorrhage from the same place, to the amount of a teacupful of blood. At the end of the sixth month she again lost about a cupful of blood. There were seven hemorrhages in all, five of which were profuse, producing a marked anemia of the patient and causing a great deal of anxiety as to the ultimate result. In order to have her under better control, and to be ready for any emergency that might arise, I advised her to go to the Rosalia Maternity Hospital, which she entered October 26, 1892. The last hemorrhage had occurred about a week before her admission to the hospital. During the last six or eight weeks she had remained in bed, hoping that by absolute rest the hemorrhages would be less likely to return.

Labor began October 30th, four days after entering the hospital, but at least three weeks before her expected confinement. The os uteri at the time of labor was very high up and very hard to reach. First stage of labor was very slow; dilatation not complete until early the next day. The patient by that time being pretty well exhausted, it was terminated by forceps. During labor there was only a slight bloody oozing from the fistulous opening. The child was living, but very small and thin. The placenta was found adherent just under the fistulous opening from which the bleeding had taken place, requiring manual separation. At this place, the hand in the uterus noted an apparent absence of the uterine wall, and the placenta seemed to be attached to the abdominal wall, around the external sinus. The abdominal wall was extremely thin, as could be easily ascertained by the hand placed over it and pressing against that in the uterus. After emptying the uterus it contracted at once, leaving a small depression in the abdominal wall around the fistula. The loss of blood during the third stage of labor was not considerable. Patient made an uninterrupted recovery and left the hospital on November 28th, with a living, healthy child, just four weeks after her delivery. The fistulous opening had become perfectly closed by that time.

Mrs. L. presented herself to me for examination May 2, 1893, with her child, which was hearty and well. The patient has been

in good health since she left the Maternity Hospital. She has not menstruated since, and she is still nursing her child. Abdominal wound perfectly healed; no trace of fistulous opening. The cervix is very high up in the pelvis; uterus small, measuring two and one-half inches, still firmly attached to the abdominal wall. The body of the uterus seems to consist of two distinct cavities, the one on the left evidently being the uterine cavity proper; turning the sound a little to the right, it enters another cavity which is about one-fourth of an inch deeper than the other and leads to the bottom of the abdominal cicatrix, the former fistulous opening, at which place the point of the sound can be distinctly felt directly under the cicatrix.

There is no doubt in my mind that the slough under the elastic ligature extended into the body of the uterus and on separating opened the uterine cavity, and that there was a direct communication between the fistulous opening in the abdominal wound and the uterine cavity, which allowed some of the menstrual blood to escape through it at her menstrual period; and that, furthermore, the source of the hemorrhages during pregnancy was the placenta itself, the upper edge of which was attached immediately under the bleeding surface.

Menstruation through an abdominal fistulous opening occurred in another case in which I removed a fibroid tumor of the uterus with thick, short pedicle in a young woman, the case being almost identical with the one described above. The pedicle was treated in the same manner as in the previous one. During the first and second day of every menstrual period, which lasts from three to four days in all, there is a slight bloody discharge through an opening in the lower angle of the abdominal cicatrix not larger than the head of a pin, which during the inter-menstrual period is marked by a minute black spot.

Pregnancy following a complete hysterectomy, of course, would be an impossibility, but even following the more conservative operations upon the uterus for subperitoneal or pedunculated fibroids, it seems to be a very rare occurrence. In A. Martin's seventy-eight recoveries following enucleation of fibroid tumors,¹ in which the cavity of the uterus remained intact, pregnancy occurred only once; in addition to this he was able to record only two more cases in which gestation followed the same operation. In the literature at

¹ "Ueber Myomoperationen," in *Zeitschrift für Geburtshülfe und Gynäkologie*, 1890.

my disposal I was not able to find a single case followed by pregnancy in which a part of the uterus was removed, as was evidently done in the case reported.

The fact that pregnancy does occur, however, though in a very small percentage of cases, should induce us, in the first place, to practise conservatism in the performance of these operations, *i. e.*, where we have to deal with a single tumor in the uterus of a young woman which can be removed without sacrificing the whole corpus uteri, we should try, in my opinion, to preserve that organ in as nearly a normal condition as possible. This object can, in cases such as the subject of this paper, be best attained, in my opinion, by the enucleation of the tumor as practised by A. Martin. While enucleation does not increase the risks of the operation very materially, it has this decided advantage over the method employed in my case, that it leaves an absolutely intact uterine cavity without fixation of the uterus to the abdominal wall, and would, therefore, prevent any unpleasant and dangerous complications, such as encountered in the case reported.

To summarize briefly, the principal points of the case described are:

1. The menstrual discharge through a small fistulous opening, remaining after a partial supra-vaginal hysterectomy, which communicated with the cavity of the uterus.
2. Pregnancy occurring eight or nine weeks after operation in a woman previously sterile in spite of a utero-abdominal fistula.
3. Pregnancy terminating in the delivery of a healthy though poorly developed child at, or at least near, the end of her term, in spite of a firm and unyielding fixation of the uterus to the abdominal wall, and in spite of frequent and profuse hemorrhages from the placental site, through a sinus opening in the lower angle of the abdominal cicatrix.



